CALIFORNIA MENTAL HEALTH
STIGMA & DISCRIMINATION REDUCTION ADVISORY COMMITTEE

January 14, 2009 Meeting Summary

1. Welcome and Agenda Review

Julia Lee, Facilitator from the Center for Collaborative Policy (CCP), Sacramento State, welcomed people to the fourth meeting of the California Mental Health Stigma and Discrimination Reduction Advisory Committee (AC for short), held at the Sacramento State Alumni Center in Sacramento. Julia reviewed the meeting objectives and walked AC members through the day's agenda, which was focused on identifying recommended actions related to target populations for the plan. All the day's materials are posted online on the AC's website, http://www.dmh.ca.gov/PEIStatewideProjects/AdvisoryCommittee.asp

Julia also introduced Joan Waters, the writer for the project, and Peggy Fish, a librarian with the California State Library that is providing research assistance for the project. Julia noted that several additional subject matter experts would be joining the Committee for small group work today.

Julia pointed AC members to an initial draft of core principles and strategic directions developed from the previous meeting. She also noted that the public workshops would be moved back from February to March.

2. Preliminary Findings on Strategies from the Literature

Kirsten Deichert, Information Officer for Communications and External Affairs, DMH, welcomed AC members. She provided a brief presentation on preliminary findings from a review of primarily academic literature on strategies to reduce stigma and discrimination. She provided a companion annotated bibliography so AC members could follow-up with specific references as desired. The presentation and bibliography can be downloaded from the main AC website listed above. In the months ahead she and her colleague Jordan Blair will review additional materials.

Kirsten noted five general strategies that were common: protest, education, contact, empowerment, and consequences (i.e., legal attempts to outlaw certain types of discrimination).

She stressed that all strategies had positives and drawbacks, and that no one strategy was the best.

On the topic of contact, she noted that this was an effective way to change attitudes and stereotypes and sometimes behavior. Having the contact person be a peer or an equal was important, along with interacting rather than just presenting. The contact person must also convince the audience that they actually live with mental illness.

Kirsten then switched and reviewed the successes of some major groups around the world. The World Psychiatric Association found that education must be done repeatedly over the long-term, and that education must focus on day to day experiences that need to be addressed in order to be relevant to consumers and family members. Many projects have established guidebooks and toolkits. The National Institute for Mental Health in England emphasized the importance of planning for the long-term and also evaluating efforts. A New Zealand study foregrounded the importance of senior government leadership and dedicated champions that would keep this a priority over the long-term. A common theme was the importance of communicating results properly so that efforts to change attitudes and behaviors continue to garner support.

Kirsten noted limitations of the preliminary findings. There was limited time and so not all recommended materials have been reviewed. Certain issues had very light coverage because materials were lacking. A major problem is that most studies focused on college campuses rather than community settings dealing with specific target populations. Sample sizes were also often quite small. Few studies looked at long-term behavioral change, and many were questionnaires that relied on self-reporting. Finally, Kirsten emphasized that the different studies focused on different goals – help seeking, increasing knowledge, and changing attitudes, etc., and this needs to be kept in mind when designing strategies.

Kirsten noted that a small workgroup will be formed to focus on research and evaluation needs. Kirsten suggested that an evaluation component be built into any actions in the plan because the diversity of California age groups and communities provides outstanding opportunities for learning what works for specific target populations and what does not.

COMMENTS AND QUESTIONS

1. *The emphasis on social inclusion over and over again is greatly appreciated, it feels good to see that as a child advocate. The bibliography has good references on children, but the AC should not get too focused on bullying. The Journal of Emotional Abuse has highlighted that psychological abuse from social exclusion and isolation is another very real issue that has nothing to do with physical aggression.* Response: Cyber-bullying on the internet is also a new issue, where kids use new media to pick on each other.
2. *One thing that's missing is research on compassion like that done by the U.S. National Institutes of Mental Health. Regarding evaluation, we need to make sure we collect baseline data to begin with. Finally, I have experienced times when I give speeches on stigma and discrimination and am discounted because I am a psychologist not a psychiatrist.*
3. *Three things to mention: (1) We need to think, How do we know that things are changing in the right direction when any intervention is made? There are lessons to be learned from movements dealing with breast cancer and premature ejaculation. (2) We need to think,*

What does stigma do that prevents people from being aware of what's happening to them, that makes them stay away from services and that prevents their recovery? (3) Baseline, I agree, is very important. The California Health Interview survey – the largest health survey in the country – had three or four questions on stigma, and would be a good source of information.

4. *Contact does not necessarily translate into a more egalitarian view. Second, we need to look at other social movements against racism and homophobia and look at the direct actions and boycotts and other things they did but we haven't done. Finally, the law can reify stereotypes, like Laura's Law which was passed as a public safety measure but legitimizes a violent stereotype and specter of dangerousness.*

5. *Like Harvey Milk said, professionals need to come out beyond signing the diversity statement where they work and let their peers know what's going on.*

6. *It looks like the earliest research in the annotated bibliography dates back to 1997. There is a very deep body of knowledge on stigma done 30 or more years ago, everyone from Thomas Merton to Talcott Parsons to Irving Goffman and others. They spoke to the issue of the stranger and the cultural and discriminatory aspects of that concept. All cultures have a concept of the stranger. I try to find the underlying commonality that the public and professionals can come together on, and for me it is that mental health is a continuum. No single part should be emphasized above others, because that allows us to get away with thinking, I'm not like you.*

7. *There is discrimination between consumers based on ethnicity, diagnosis, and higher versus lower functioning. I also disagree about coming out – for many ethnic consumers it's not an individual decision, it's a family or collective decision. Ethnic communities need to be involved in redefining what recovery is and supposed to look like. There's also discrimination between English and Spanish consumers, from outright racism to undertones to setting up meetings.*

8. *On research limitations, it seems that very few studies looked at people in locked mental health facilities and probably fewer in jails and prisons. A U.S. Department of Justice study found that fully 65% of the people in jail in cities, counties, states, and the federal system are diagnosed with serious mental illness, and the percentage increased 10-15% over the past ten years. So we need to look not just at racial disparities in sentencing but also mental health disparities.*

3. Development of Actions for Target Populations

Julia went over the small group work that AC members would engage in for the rest of the day. This involved self-selecting into work groups focused on specific target populations and having extended small group discussions focused on generating actions for these populations. Each group had a facilitator and recorder. There would be two sessions over the course of the day, and people could switch groups between the first and second. Not all topics would be covered during both the first and second sessions.

The eight target population workgroups included:
    (1) Children
    (2) Racial and Ethnic Communities
    (3) Adults
    (4) Co-Occurring Disorders

(5) Transitional Age Youth
(6) Rural
(7) Homeless
(8) Older

Two additional workgroups, LGBTQ and Veterans, did not meet, but in each case a small AC workgroup will be put together outside of the regular meetings.

The appendix contains a full list of the recommended actions generated by each workgroup. Some additional notes are included when relevant. Julia explained that all workgroup members would be provided with an opportunity to review draft recommended actions before they were included in the notes.

4. Gallery Walk

After the small group work was completed, AC members and guest experts walked around the Alumni Center and reviewed the actions that had been written on large paper and posted on the walls. In some cases they added additional actions with Post-It notes.

5. Wrap Up, Homework, Meeting Evaluation

The February 3 meeting will use a similar workgroup format, but will focus on systems where stigma and discrimination need to be reduced.

Staff will try and finalize the dates and locations of the public workshops by the next meeting. There will be two, one in northern and one in southern California. The key factor in choosing sites is accessibility by public transit. Translation will be provided as needed, including for the outreach flyer. Anticipated attendance is around 100 people at each event.

Julia then led the group in evaluating the meeting.

PLUS	CHANGE
+ The format was good for being heard, getting ideas, processing them, and working in a group	Δ Need more coffee, and soda and candy
	Δ Need more breaks and exercises
+ Tried to make sure everyone gets heard and nobody talks extendedly	Δ Sometimes hard to hear in the small room because of the other groups
+ Glad that all individuals had a voice in the process	Δ The small room was too warm

The next meeting is Tuesday, February 3, 2009, **and will be held again at the Sacramento State Alumni Center** (not at the University Union, as previously noted).

7. Attendance

Committee Members:
Jennifer Alvidrez
Delphine Brody
Rocco Cheng
Rob Chittenden
Serena Clayton
Kita Curry
Natalia Deeb-Sossa
Fran Edelstein
Luis Garcia
Marty Giffin
Lisa Harris
Tish Harris
Susan Henderson
Elisa Herrera
Stephen Hinshaw
Stacie Hiramoto
Lorna Jones
Janet King
Jay Mahler
Daniel McCarthy
Arnulfo Medina
Bonnie Milstein
Marie Nitz
Becky Perelli
Stephanie Ramos
Dede Ranahan
Sharon Rapport
Sean Rashkis
Emil Rodolfa
Cuco Rodriguez
Michael Roosevelt
Gregory Sancier
Ron Schrabier
Steve Segura

Jenessa Shapiro
Diane Shively
Alysa Solomon
Sheryle Stafford
Hector Torres
Philip Traynor
Sue Watson
Jennifer Whitney-Tucker

Guest Subject Matter Experts:
Sergio Aguilar-Gaxiola
Jakki Carrillo
Tonya Edelman
Geri Esposito
Hope Holland
Joyce Ott
Lou Williamson

DMH, OAC, and CCP Staff:
Cielo Avalos, DMH
Jordan Blair, DMH
Kirsten Deichert, DMH
Peggy Fish, California State Library
Dorian Fougères, CCP
Nancy Kincaid, DMH
Julia Lee, CCP
Christal Love, CCP
Sam Macgill, CCP
Susan Sherry, CCP
Jennifer Turner, DMH
Nicole Ugarte, CCP
Joan Waters, CCP
Beverly Whitcomb, OAC
Sue Woods, CCP
Tina Wooton, DMH

Appendix A: Recommended Actions for Target Populations

I. Children
INTRODUCTION

For children with social, emotional, and behavioral challenges, stigma and discrimination means that these children frequently experience social exclusion, isolations, and acts of aggression and

sometimes violence by other children. They are routinely treated differently than other children by both the adults who work with them and their peers.

Families of children with social, emotional, and behavioral difficulties suffer blame, judgment, and shame. The problems of siblings unfortunately are often overlooked because the family's focus is on the child with the more sever difficulties. Sometimes families scapegoat the child with the social, emotional, or behavioral difficulties, making these children the 'identified patient.'

The language of mental illness does not help these children. Using such labeling reinforces discrimination, which in turn reinforces denial, fear, and shame on the part of families and self-stigma on the part of these children. Rather than use mental illness language, it is more helpful and accurate to describe these children as experiencing social, emotional, or behavioral challenges.

Additionally, describing mental health along a continuum of wellness helps normalize children's social, emotional, and behavioral challenges and is a particularly helpful concept for families trying to understand their child's problem. The mental health continuum concept can be used on a universal basis for all children, and thus, is an important and responsible tool for reducing stigma and discrimination.

Lastly, it is very important that the California Plan for Mental Health Stigma and Discrimination Reduction model language that is supportive of children's healthy development and resilience and address children's mental health issues separately from stigma and discrimination toward adults.

I. FAMILIES

A. Develop "informational intervention" programs that provide education and guidance to parents of children with social, emotional and behavioral challenges. Too often, parents and families desperately need accurate information and do not know where to turn for help.
   1. Create the expectation that meetings between parents and those in the community whose job it is to work with their children hold parent conferences at "family-friendly" times (e.g. evenings; weekends).
   2. Promote home-visitation by teachers and schools.
   3. Establish speakers bureaus around the state whose mission is to provide information and education to families and parents.
   4. Establish a 1-800 statewide call-in number for parents needing information and referrals for their children. This program would be similar to "advice nurses" that operate in the medical arena.
   5. Provide training for "first responders" and "gate-keepers" on children's mental health issues and on the resources available in the community to help parents. First responders and gate-keeepers are those in the community that have routine contact with children (teachers, school administrators, recreation program staff, etc.).

6. For those professions that have routine contact with children and are also subject to a state licensing, establish a training requirement on childhood mental health issues.
7. In the development of the above educational programs, integrate information on child development, how children's brains operate and how trauma adversely affects children.
8. Educate parents and families to pay as much attention to their children's mental health as they do to their children's physical health
9. Establish educational programs for preventing and reducing childhood mental health challenges that are universally available to all parents.
10. Encourage First 5 California to expand their statewide parent Tool Kit to include information to assist parents in identifying and addressing the mental health challenges of their children, including where to find other informational resources and where to go for help.

B. Establish programs that provide support to the parents, care-givers and families of children with social, emotional and behavioral challenges.
1. Develop an awareness campaign that commends and supports parents who seek and receive mental health assistance and services for their children and themselves.
2. Establish respite care programs for parents and care-givers.
3. Create programs designed to provide support to the siblings of these children.
4. Recruit leaders and persons with "pulpit power" to speak out about childhood mental health issues, the importance of social inclusion to a child's development, and the need to respect the differences among children.

II. COMMUNITIES

A Initiate a multi-pronged effort that involves and engages an entire community to embrace, respect and support children with social, emotional and behavioral challenges and their families. Many parts of the community touch children's lives – for example schools, sports teams, child care facilities, neighborhoods and the many places children naturally gather.

Contact groups and organizations that have a mission and history of service work and "good deeds." There is a wide range of such groups and organizations in the community, for example scout programs, neighborhood associations, chambers of commerce, social clubs, etc. Work with these organizations and groups to open their hearts and minds to accept these children and their families as vital parts of the community.
Initiate a community campaign emphasizing the value of embracing differences in all its many forms, including children who seem different than other children.
Begin a dialogue with specific organizations and groups who have routine contact with children (teachers unions, bus drivers, facility recreational staff, etc.) to educate them on childhood mental health issue, the importance of respecting differences among children, and their critical role in promoting the healthy

development of children.

As part of a larger community effort, solicit the involvement of local radio and television stations. Educate them on childhood mental health issues and on the important role they could play in promoting social inclusion. Also explain to them that children who are isolated tend to spend more time listening to radio and watching television. So, their messages can also combat self-stigma in these children.

Encourage local media to utilize children to carry the message of social inclusion. Children listen to other children more than to adults regarding messages on social inclusion.

Establish a 1-800 statewide call-in number to report incidences of discrimination against families and children.

III. SCHOOLS

A. Establish programs, policies and practices to change the culture of K-12 education from one that isolates children with differences to one of social inclusion.

1. Develop curricula and training for teachers, administrators, school support staff, and students that teach the value of social inclusion. Use youth as part of the training and curricular delivery.
2. Establish school peer support programs that teach children to stand up to rejecting and demeaning behavior toward any student, especially students who may seem different.
3. Increase the number of school-based counselors.
4. Provide for the funding of special education programs. These programs are often under or unfunded, even though under federal law schools are required to provide these services.
5. Share the trainings, curricula and other resources on social inclusion developed by public schools to private schools.
6. Extend requirements that pertain to public schools regarding childhood mental health services, education, and non- discriminatory practices to private schools.

PRIMARY CARE AND PEDIATRIC PRACTITIONERS

Develop strategies to motivate primary care and pediatric practitioners to integrate childhood mental health into the routine medical care of children.

1. Establish programs that encourage relevant medical practitioners to include mental health in well-child check ups, provide education to parents if a child demonstrates or may be at risk for social, emotional or behavioral challenges and recommend to the parents the appropriate next steps for obtaining help for their child.
2. Develop trainings and written education materials to assist the appropriate medical practitioners understand, identify and treat childhood mental health problems as well as provide guidance, information and referrals to parents.
3. Distribute the existing children's mental health screening instrument developed by the

State Department of Education to relevant medical practitioners.
4. Establish medical school and other health-related professional degree requirements for childhood mental heath issues, including the identification and treatment of children with social, emotional and behavioral challenges.
5. Develop a strategy to establish Same Day Visit Reimbursement for community health centers and Federally Qualified Health Centers
6. Eliminate medical necessity criteria under Managed Care Mental health for County Mental Health
7. Support concept of integrating behavioral health services into primary care/ community health centers.

Develop strategies to develop alliances between primary care and pediatric practitioners and the community on childhood mental health issues.

. Encourage relevant medical practitioners to create channels of communication with preschool and child care programs focusing on the identification of childhood mental health difficulties. And access to appropriate community resources.
2. Encourage parents, families and consumers to organize meetings with relevant medical practitioners to raise their awareness of childhood mental health issues.
3. Establish a community network of families, medical practitioners, schools, human service workers and others with routine contact with children to meet on a regular basis to identify and implement strategies for reducing childhood mental heath problems as well as stigma and discrimination that often accompanies childhood social, emotional and behavioral and problems.

Establish enhanced MediCal reimbursement for medical practitioners how include mental health check-up into their care of children.

MEDIA AND MASS MARKETING

In their programming for children, encourage print media, radio, broadcast television and the video game industry to promote social inclusion and respect for children perceived as different.

1. Establish organizations/ networks charged with identifying radio programs television advertisements and televisions productions geared to children that sanction social exclusionary behavior, stigmatizing behavior, and /or violence toward those that are perceived as different, especially children with social, emotional and behavioral challenges. Contact these media to raise their awareness and work with them to promote positive social behavior in their programming.
2. Encourage media and other vehicles for mass marketing to utilize children to deliver messages promoting social inclusion and respect for children perceived as different. Children to children communication can be very effective.
3. Develop guidelines for the media reporting on childhood mental health issues. Use these guidelines to promote accurate and informed portrayals of children and adults living with mental health difficulties.

Create an organization / network dedicated to working with the video game industry to reduce the level of violence and social exclusionary behavior in video games

VI.. FOSTER   CHILDREN

The Children's Work Group recommends that a separate work group be formed to develop actions for Foster Children. The Children's Work Group also recommends that the work group on Foster Children contact youth organizations for insights and advice (e.g. Youth and Mind; CYC; California Youth Connection; UCAF; etc.). The Children's workgroup had the following recommendations:

1. Develop and implement programs to educate foster care parents on issues relating to childhood social, emotional and behavioral challenges.
2. Develop a CASA program for foster care parents to enable them to advocate for foster care children.
3. Work with the foster care system to provide increased long-term consistency between a specific service provider /therapist and a foster child.

II. Racial and Ethnic Communities

The community's perspective on what stigma and discrimination looks like and how it is defined is critical in efforts to reducing mental stigma and discrimination in racial and ethnic communities. Given the overall goal is recovery for someone with mental illness, the group emphasized how this outcome is severely limited due to the lack of culturally appropriate services for ethnic communities.

The group identified three topics of highest concern in developing draft actions: funding equity, treatment and services, and awareness. Other topics of concern identified included: partnering with community based organizations, barriers to access, and education on issues of racism and equality leading to leadership and media efforts.

COMMUNITY PERSPECTIVE

1. Utilize a community and consumer perspective to inform messages and an understanding of what works at local level. Comment: This item is vague.

2. Recognize that uniqueness and diversity is important in how approach efforts and that color blindness will not get to effective change. Comment: Hard to understand.

FUNDING

1. Appropriate funding at the local level specific to ethnic communities, reflective of the % of the population in the community to ensure equity in funding across all populations in California.
   Comment: Need to qualify reflective of % as some populations are not captured well in census data so perhaps a statement like "using reliable sources known to underserved

*populations to determine their percentage". This statement will protect populations that
are misclassified in census data.*
*Comment: The funding action item #12 below "might be a good addition as an
alternative method of determining worthiness of funding. For reference it reads:*
Distribute funding by need rather than census/service recipient data by informing the
definition of need that currently is defined in three ways.
Comment: This should be broader. Are we realy suggesting providing funding based on
numbers not need?

2. Develop a *new* funding accountability mechanism, a local governance group,
    representing various communities served to monitor how funding is actually spent
    including for example: NAMI, MHA's Advocates, and Community Based Organizations.

3. Develop within *current* existing governance structure funding accountability to the
    communities they serve. Examples of existing governance structures: Planning
    Committees, Mental Health Boards, MHSA Steering Committees.

    Comment: What is the accountability?

4. Coordinate between state and local activities to eliminate duplicative efforts and foster
    collaboration. Reword so reads: Eliminate duplicative efforts and foster collaboration
    between local and state activitites.

5. Fund programs based on achievement of benchmarks, outcomes, and deliverables.

    Comment: Reword so the benchmarks are determined to be reached after funding
    provided for a program.

6. Ensure funding for (rather than wording spent on) *culturally effective practices*.

7. Enforce *with consequences* compliance with existing cultural competence provisions for
    county contracts with states.

8. Establish evaluation that is based on *culturally competent indicators of success* that are
    relevant to the communities.

9. Fund the evaluation (rather than word validation) of practices that are now used by
    communities.

10. Fund participation of representatives from cultural communities at state and county levels
    to provide advice and afford the opportunity to develop the capacity to be at the table to
    advise and ensure that services are being improved for cultural communities.

    Comment: Reword to make clear.

11. Pool resources among counties to make a bigger impact across the state for cultural communities and indigenous communities.

12. Distribute funding by need rather than census/service recipient data by informing the definition of need that currently is defined in three ways.

    Comment: What are the three ways?

13. Fund educational materials that are written by communities that know what works for them.

14. Fund the development of consumer-led advocacy, educational, and service programs within cultural communities.

AWARENESS

1. Ensure community perspectives are determinates of what stigma and discrimination looks like.

2. Develop mandates and policies to develop acceptable norms to change institutional cultures including defining acceptable language, behavior and practices.

    Comment: needs more specificity.

3. Address internalized racism and recover own cultural traditions.
    a. Examples: TAY program for African American boys (in Los Angeles), Critical Thinking, Cultural Affirmations, PRIDE (A.M.A.S.S.I.) and Latino Program El Joven Noble, Daughters of Tradition and Sons of Tradition and other White Bison curriculums for Native American Youth.

4. Frame training so the training itself is less stigmatized such as what is called to make more integral to interests of those trained.
    Comment: unclear

5. Recognize that mandatory training may in fact be less embraced than when voluntary.
    Comment: Is this a recommendation? Reword.

6. Help elders and youth when reintegrating keep identity intact to resist challenges.
    Comment: Challenges always exist. Need clarity.

7. Adopt 14 federal standards of cultural competency.
    Comment: Add citation.

8. Increase commitment and infusion in education of professionals rather than a stand alone class.
   Suggested rewording: Increase commitment training in diversity and infuse diversity training into professional education as a stand alone class is not sufficient training.

9. Increase leadership for enforcement of training efforts.
   Comment: What?

10. Establish allies via training for <u>new staff</u> that are diverse and reflect the population served AND <u>existing staff</u>.
   Comment: Needs clarity.

11. Provide workshops to educate providers including medial schools.
   Comment: needs clarity.

12. Educate target groups from community perspective that incorporates cultural, linguistic and health literacy
   Comment: list target groups…who?

ACCESS

1. Work with alternative healers.

2. Identify key access points such as:
   o Laundromats
   o Prisons
   o Barbershops, Salons
   o Churches
   o Or other ethnic gathering places and events such as cultural centers of ethnic specific community based organizations (CBO's).

3. Identify the gatekeepers who have direct access to target populations and recruit to develop messages to target populations, e.g. coaches for young men.
   Comment: this is multiple item and could be divided up.

4. Identify what has worked in HIV, teen pregnancy, reproductive health, sexuality, etc. within cultural communities on stigmatized issues that is evidence based and known to be successful locally. Also, depression is a real campaign example for men in Spanish language.
   Comment: too many words, needs focus.

5. Adopt lessons learned for immigrants from Latino program in Indiana, Bienvenido, that helps identify what issues they will encounter in government systems.

6. Tailor and deliver messages based on asking particular ethnic group what are the message and how can they be delivered effectively.

7. Use out of the box methods as answers may not be in the literature such as:
   a. Dramatization, interactive community theater.
   Comment: not congruent with earlier statement of empirically supported.

8. Identify what can learn from various medium
   a. TV/Movie industry. Examples: Dawson's Creek on contraception, Secret Life of Teenagers, Nik., Telenovellas
   b. Photo novellas (graphic novels)
   c. AM Radio
   d. Brunches for Latinas (done in San Diego)
   e. Photo Voice (in Los Angeles) with young adults to tell their story with technology
   f. Initiate reading groups/book clubs around literature that is relevant.
   g. YouTube
   h. My Space

9. Engage consumers as advocates, educators, and agents of change.
   Comment: not sure what means.

10. Utilize the targeted populations in the development of actions and materials.
    Comment: not sure what this means.

11. Develop advocates who are leaders to empower the community to be involved, have a voice and be roles models of practices that work that incorporates cultural sensitivity. Example: Crossing Boundaries by the California Endowment.

12. Implement Title VI language.

13. Integrate health and mental health system as it is the <u>health</u> system that is used by people to seek help.
Comment: Restate as: Utilize primary care and behavioral health models to enhance mental health services.

14. Raise awareness in messages that include: symptoms, treatable, recognition, mainstream, understandable, and how to act upon.
Comment: Restate as: Raise awareness by developing understandable, mainstream messages that describe recognition of symptoms, treatment.

15. Develop understanding that increasing access for cultural communities does not mean just bringing ethnic communities to existing services but making culturally competent services available so ethnic community members return to them after one visit. Research bears out that some ethnic community members drop out of services after one visit because of lack of cultural competence.

TREATMENT/SERVICE PROVISIONS

1. Provide competent early diagnosis and assessment utilizing culturally valid measures for the culture. These already exist.
    Comment: reword to: Provide culturally competent assessment and diagnosis.

2. Focus on a recovery model to minimize oppression of cultural communities.
    Comment: There are a number of recovery models. Which one being referred to.

3. Utilize traditional and indigenous models of treatment to minimize people dropping out.

4. Foster relationship building to minimize drop outs.

5. Utilize consumers as providers or outreach workers.

6. Integrate family and community members in the treatment and healing, recognizing we all have a stake and are part of a person's recovery.
    Comment: the important issue here is the clarify who is the client.

7. Respect client's familial, cultural, and spiritual upbringing and context.

8. Recognize the whole community may be the client as nobody has escaped the suffering and we all bear the burden. This approach of seeing the whole community as client is different from the mainstream approach of seeing only certain individuals as client. This holistic approach better lends itself to reducing stigma as all bear the symptoms of collective despair with on one earning a negative label because of it.

III. Adults

As the broadest demographic in the mental health community, adults face diverse challenges across systems in society. In addition to internalized stigma, adults often feel helpless against organizations that are not equipped to offer opportunities for success and wellness. Adults in the mental health community strive for fairness in public policy, media, the criminal justice system, and in opportunities for services and employment.

Adults look to collaboration and education as the most effective tool for reducing mental health stigma and discrimination. By partnering individuals and organizations in a strength-based, peer supported strategy, consumers will become better informed of what is accessible to them, and those who collaborate with the mental health system will better understand the challenges the community faces.

STIGMA & DISCRIMINATION STRATEGY

1) Provide consumers with:
    a. Strategies for resolving internal stigma
    b. Training on community policy and laws regarding mental health
    c. Train on Peer Support, strength-based
    d. Leadership and Trainer Skills
2) Organize Consumers and Mental Health Professionals to partner and network to provide training and education to identified consumers, families, government, and community, utilizing new and existing resources

EDUCATION & TRAINING

Consumer/Family created and delivered or in Partnership with mental health professionals. Review training from effective programs and campaigns, then expand and convert to larger target audiences.

Topics of training for Consumers/Families
☆ Collaboration Skills
    o Communication
    o Teamwork
    o Self-respect
    o Respecting others
    o Assertiveness
    o Empowerment
☆ Community Advocacy, Systems Advocacy
    o County and state policy
    o Political systems
    o Leadership
    o Negotiation
☆ Consumer Rights
    o Discrimination
    o ADA
    o Access to services
    o Forensic
    o Conservatorship
☆ Custody Issues

Providers
☆ Training graduate and undergraduate mental health students
☆ Training first responders in crisis intervention
☆ Training for Human Resources personnel
☆ "Respect" concerns (general practice)
☆ Educate Landlords
☆ Educate other Providers
    o Housing
    o Business

- o Employers
- o Law enforcement
- o Elected officials
- o Senior centers
- o Faith-based organizations
- o Media

Means/ Approaches of Education/Training
- ☆ Dialogues between consumers and mental health professionals
- ☆ Create Speakers Bureau
- ☆ Storytelling
- ☆ Utilize video, photos, writing, WRAP groups, theatre, internet
- ☆ US + THEM = WE program

Public Policy Revisions
- ☆ Create state based policy establishing guidelines/training requirements for first responders
- ☆ Revise agency policies requiring a minimum % of employees be consumers (suggested 25% minimum)
- ☆ Review and change Human Resources rules to allow safe disclosure related to employment
- ☆ Change community care licensing to allow consumers with minor-non-employment related crimes to work in residential programs
- ☆ Change Human Resources policies to allow employment of consumers with minor/status offenses
- ☆ *Develop a strategy to establish Same Day Visit Reimbursement for community health centers and Federally Qualified Health Centers*
- ☆ *Eliminate medical necessity criteria under Managed Care Mental Health for County Mental Health*
- ☆ *Support concept of integrating behavioral health services into primary care / community health centers.*

MARKETING
- ☆ Develop a budget and a timeline based on stigma and discrimination MHSA funds for a long term adult media campaign
- ☆ Hire a professional marketing firm to develop the media campaign in a culturally competent manner
- ☆ Share stories of:
  - o Personal interest stories
  - o Stories to counter stereotypes
  - o Positive stories about MHSA
  - o Families and clients

- ☆ Other Ideas:
  - o Utilize NPR and local public radio

- o Develop consumer and family run TV and radio shows
- o Train families and consumers in how to use media
- o Tell our stories: in person, video, theatre, internet

✪ Use celebrities and "real people" in media campaign
✪ Identify effective locations and methods for message delivery

CRIMINAL JUSTICE
✪ Train criminal justice professionals and offenders regarding:
- o Mental health
- o Access to legal and mental health systems
- o Housing
✪ Ensure a criminal justice background is not an intrinsic block to employment
- o can be an asset as experience in recovery, a better role model

OTHER:
✪ Creating partnerships among all organizations who serve the mental health community
✪ Identify current and effective programs, then ask Department of Mental Health to support local community efforts

IV. Co-Occurring Disorders
Actions to Reduce Stigma and Discrimination Experienced by People Living with Co-Occurring Disorders

OVERARCHING RECOMMENDATIONS
1. Educate people that recovery from mental illness and disabilities is possible, and initial diagnoses can change over time.
2. Shift from treating mental health and disabilities in isolation to treating the whole person, as in public health.
3. Establish a continuum of care from support centers through crisis services through case management programs through recovery.
4. Normalize language so that the terms and descriptions of people with co-occurring disorders emphasize strengths, positives, and potentials.
5. Create opportunities for people living with co-occurring disorders to tell their stories in multiple arenas.
6. Adopt at the State and county levels a definition of "co-occurring disorder" that goes beyond substance abuse to include developmental, physical, and trauma-related disabilities.
   a. The definition must be widely recognized and adopted for it to attract funding.

SYSTEMS AND AGENCY RECOMMENDATIONS
7. Provide technical assistance and funding for education and training programs that reduce stigma and discrimination against people with co-occurring disorders in both the mental health and non-mental health systems (e.g., criminal justice, foster care).
8. Involve people living with co-occurring disorders in the development of such programs.

9. Develop a formal state process for coordinating and integrating the actions of State and county agencies that separate the treatment of mental illness and disabilities.
10. Collaborate with the Governor's Prevention Advisory Committee and other major initiatives.
    a. Examples include the Co-Occurring Joint Action Council, Harm Reduction Coalition, Substance Abuse and Mental Health Services administration (SAMHSA), National Alliance on Mental Illness (NAMI), California Network of Mental Health Clients (CNMHC), Twelve Step Council, Peace Office Standards and Training (POST), and National Association of State Mental Health Program Directors (NASMHPB).
11. Establish and fund inter-agency case management teams that review cases and help people living with co-occurring disorders navigate across systems.
    a. Teams should include, but are not limited to, mental health, primary care, corrections, law enforcement, and housing agencies.
12. Require that MHSA Full Service Partnerships do not exclude people based on substance abuse and, conversely, require that substance abuse agencies to not exclude people living with mental illness.

RESPONSE AND TREATMENT RECOMMENDATIONS
13. Promote the establishment of contact, training, education, and mentoring programs for emergency personnel that involve people on the street <u>and</u> people who have recovered.
    a. Emergency personnel include but are not limited to paramedics, police, nurses, first responders, and emergency room doctors.
    b. Contact models include Stamp Out Stigma and Paula Comunelli's Listening Well.
14. Inform all care and services for co-occurring disorders with sensitivity to trauma and harm reduction.
15. Require that law enforcement officers place people with co-occurring disorders and under the influence in detoxification in psychiatric facilities, and never in seclusion or restraints.
    - [COMMENT FROM AC MEMBER: This needs to be clarified/have greater specificity.]
16. Promote peer overdose prevention programs.
17. As part of a continuum of care, promote the adoption of Harm Reduction programs that focus on reducing harm to the self and others.

PEER-BASED RECOMMENDATIONS
18. Promote the development of peer-based services throughout a continuum of care.
19. Provide both peer bridgers and inter-agency case managers as a routine procedure, from the moment when the emergency system is contacted, through the courts, recovery, and obtaining housing, employment, and psychiatric care.
    a. Peer bridgers serve as liaisons to help people with co-occurring disorders navigate the multiple mental health and non-mental health systems.
    b. The federal Mentally Ill Offender and Crime Reduction Act (S. 1194) of 2004 provides a foundation for this (it aims to improve access to mental health services for adult and juvenile non-violent offenders).
20. Promote the establishment and funding of peer-driven, peer-run crisis respite centers to help people with co-occurring disorders stay out of hospitals.
    a. One model is Self-Help and Recovery Exchange in Los Angeles.
21. Provide peer-based training for hospital administrators and clinical directors.

LEGAL RECOMMENDATIONS

22. Provide independent legal advocacy for people with co-occurring disorders in all contexts (e.g., primary care, addiction programs, halfway houses, twelve-step programs).
23. Promote the use of Mental Health Drug Courts that coordinate the efforts of the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities.
24. Eliminate the legal barriers that prevent people with documented recovery from becoming peers and professionals.
    a. Clearing criminal records is not enough – records need to be expunged.
25. Work with mental health courts, judge champions, and advocacy groups to lobby for the elimination of these barriers and a written process for restoring these civil rights.
26. Partner with civil rights groups to learn techniques and strategies for reducing discrimination, increasing solidarity, and transforming culture.
    a. For example, NAACP, United Farm Workers, American Justice
27. Request the California Law Revision Commission to make recommendations to the Legislature to remove discriminatory language that is embedded in statute.
28. Require the State to develop a board that requires and oversees that State agencies accept people with documented recovery to work directly as peers.
29. In the housing sector, outlaw the discrimination against people with co-occurring disorders based on requirements for being absolutely clean, sober, and relapse-free.
30. Promote the adoption of Housing First programs that focus on providing housing regardless of co-occurring disorders.

EDUCATION RECOMMENDATIONS

31. Require the curricula for mental and medical health degree programs to include an education and training component on co-occurring disorders and integrated treatment models.
32. Train higher education counselors, dormitory supervisors, and residence assistants how to recognize the symptoms and respond appropriately to co-occurring disorders.

V. Transitional Age Youth

OVERARCHING RECOMMENDATIONS

1. Ensure the meaningful involvement of transitional age youth in all phases of stigma and discrimination reduction policy and programs, from planning and design through implementation and evaluation.
2. Recognize the distinctiveness, importance, and vulnerability of transitional age youth at the highest levels of State government.
3. Shift from treating mental health in isolation to treating the whole person.
4. Develop a transitional age youth system of care, including wards in hospitals and treatment centers, that is separate from those for children, adults, and older adults.
    a. The Adult Allies group that meets with the California Mental Health Director's Association has already been advocating for this, what's needed is county buy-in.
    b. When a youth turns 18, the sudden movement from a child to adult facility can be terrifying and cause both internal and family stigma.

5. Normalize language so that the terms and descriptions of transitional age youth and associated facilities emphasize strengths, positives, and potentials.
    a. For example, do not label a facility a "mental health center" (as does the MHSA) but rather a "community center." Transitional age youth avoid these because of the stigma. For example, using the term "kids" is derogatory.
    b. San Bernardino County's transitional age youth centers are a good example – they help with jobs, education, resume building, and are not advertised as mental health locations. This is an example of the whole person philosophy.
    c. Alameda County's Youth Uprising center is another good example
    d. Normalizing language is a more general theme – mental illness is a spectrum and everyone experiences it, so more inclusive language is needed.
6. Ensure that programs and events involving transitional age youth are properly scheduled (i.e., during evenings and on weekends).
7. Communicate with transitional age youth using internet-based channels.
    a. Australia's Reach Out platform has been tested and can easily be adapted to California.
8. Ensure that the aspects of this strategic plan that deal with transitional age youth are vetted with them.
    a. One option is to work through the Mental Health Association's California Youth Empowerment Network (CAYEN)
9. *Vet these recommendations to transitional age youth directly and have them finalize the approach/strategies.*
10. *Ensure that strategies/approaches include language that supports historically marginalized youth groups, racial/ethnic, LBGTQ, foster youth, and juvenile justice.*
11. *Consider including the Student Mental Health Initiative recommendations regarding college students* (http://www.dmh.ca.gov/MHSOAC/docs/Meetings/2007/StudentMentalHealthInitiative_091807.pdf) *including:*
    a. *Training: The grant program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health and wellness on college campuses. The training would be designed to improve recognition and responses to students experiencing mental distress, to reduce stigma and discrimination against persons who become identified with mental illness, and to promote a campus environment that enhances student success providing hope, supporting resiliency, and creating a healthy learning community.*
    b. *Peer-to-Peer Support: These activities would focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies, and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness, and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.*
    c. *Suicide Prevention: This project would be designed utilizing the resources and best-practices of the MHSA suicide prevention efforts or knowledge of the assigned workgroup but would focus specifically on addressing the unique needs, vulnerabilities and risk factors of university and college students, and would bring*

suicide prevention resources directly onto campuses to raise their profile among students and to make them as accessible, relevant and effective as possible.

PEERS, PROGRAMS, AND FACILITIES RECOMMENDATIONS

12. Hire transitional age youth to implement and run programs, centers, and facilities designed by and for them.
    a. San Bernardino has two facilities that involve and employ transitional age youth significantly, and that are contracted out to community-based agencies.
    b. Note that the word "contracting" is loaded and can imply many things. On the one hand, it can be used simply to indicate that facilities are not run by State or county staff. On the other, in can be used to indicate an exploitative labor relationship where employees do not accrue paid vacation and other benefits. In this way the term can create its own stigma and should be avoided.
13. Encourage peer-to-peer education for transitional age youth.
14. Involve transitional age youth in conducting outreach that reduces stigma between transitional age youth living with mental illness and those not.
15. Fund programs and events designed specifically for transitional age youth, particularly recovery programs.
16. Establish a statewide network for transitional age youth to exchange ideas, experiences, and expertise.
17. Establish a youth speaker's bureau that travels to high schools and colleges and hosts open conversations and develops an ongoing presence.
    a. Substance Abuse and Mental Health Services administration (SAMHSA)'s Eliminate Barriers Initiative (EDI) provides a toolkit for media and targets all parts of the community.
18. Host an annual statewide convention for transitional age youth "ambassadors" to exchange ideas, experiences, and expertise.

WORK ENVIRONMENT RECOMMENDATIONS

19. Prepare adults to work <u>with</u> transitional age youth – to avoid treating them in a particular manner and to provide them with opportunities to succeed on their own merits.
    a. Adults often speak down to transitional age youth and underestimate their capacity, so <u>with</u> is the critical word in this recommendation. Adults tend to pick and focus on youth that are already doing well.
    b. *Do not assume that youth can't do anything. Do not assume/expect/relay that youth can do everything. Provide adequate support and they will succeed.*
    c. Adults often try to be cool and stop being adults, and this often backfires.
20. Have transitional age youth train and better prepare adults for working together.
    a. Australia's Reach Out program has a tested training curriculum based on "meaning, control, and connectedness" that has been prepared by transitional age youth for this purpose.
    b. Program delivery by transitional age youth is critical.
    c. Both transitional age youth and adults need to be prepared to work together.
    d. *Make the environment comfortable for LGBTQ youth, provide trainings to staff and youth on current issues and topics important to this community.*

FOSTER YOUTH RECOMMENDATIONS

21. Recognize that foster transitional age youth have additional dynamics at play, and additional stigma that goes along with foster care.
22. Ensure that foster transitional age youth have access to and control over the sharing of their own mental health records, particularly when being represented by Court Assigned Special Advocates.
    a. One option is to specify an age at which they can control their records.
23. Require inter-agency coordination between courts, judges, and foster care facilities.

EDUCATION AND ADVOCACY RECOMMENDATIONS

24. Provide education and training about transitional age youth and mental illness for educators in a variety of contexts.
    a. Teachers are in an awkward position because they have responsibility for the health and safety of their students (e.g., ensuring prescribed medications are taken).
    b. Professors at community colleges are also in an awkward position because they have no direct responsibility over students, but have responsibility for helping to ensure campus safety.
25. At the county level, reorient the advocacy work of parents from deterring juvenile criminalization to emphasizing the strengths of and things that are helping transitional age youth.
    Advocacy that focuses on criminalization often comes across as controlling

VI. Rural

Stigma and Discrimination Reduction Actions for Rural Communities

Significant disparity exists between the levels of mental health services in urban vs. rural areas. Rural areas are faced with unique challenges related to access, transportation, technology, and funding levels.

Often, small clinics serve large areas of land. Transportation and physical access to mental health care become significant issues, as some consumers must travel 2-3 hours to their provider. The number of care provider choices available for consumers is substantially smaller then in urban areas as well. Innovative care that utilizes the use of technology (web conferencing, chat rooms, etc.) and peer support are critical in these areas to provide care and support on an as-needed basis.

Funding levels for mental health services also vary greatly between rural and urban areas. Public funding is generally determined by population density and per capita use. For rural consumers, this equates to fewer options, longer wait times, and greater distances to the nearest mental health provider.

In addition to service disparities, the size of rural communities creates stigma and discrimination problems not seen in urban areas. Because rural communities tend to be very small and "everyone knows everyone else," consumers face the unique challenge of everyone in the community knowing about their illness. Because of this, family members may be less inclined to acknowledge mental health challenges at home or in public.

Specific actions to reduce stigma and discrimination in rural communities include:

NOTE: Common "themes" and general areas for improvement that emerged in workgroup discussions are in **bold**. Actions specific to those themes are bulleted.

Funding
- Develop advocacy strategy to establish same day MediCal reimbursements for federally qualified health centers.
- Develop funding sources to establish technology *and* technology support to address stigma and discrimination reduction. This could include funding for internet support groups *and* internet connections for rural consumers.
- Address the fact that rural counties are exempt from some MHSA funding requirements.
- *Address rural vs. urban disparities in funding for mental health services. Oftentimes, funding for services is based on average overall facility use. Because fewer people use rural health and mental health services, these facilities receive less funding, even though the per capita use and need for services is the same as in densely populated areas. Isolation is greater in rural areas and services hard to come by because of transportation issues. In rural areas, it could be more useful to provide funding based on the size of the terrain rather than the population. In El Dorado County, the "Divide" community is 412 square miles wide, which makes services difficult to access. Acknowledge that rural funding needs are different then urban needs, and should be specific to rural communities.*
- *Take advantage of the fact that small counties have a natural built in community collaboration and networking that bridges the cost and services that large counties do not have.*
- *Consider training community services staff/volunteers to do the outreach or referrals to hard-to-reach populations*
- Develop "blended funding" sources (i.e., match mental health funding with other community funding like fire services).
- Eliminate the medical necessity criteria under managed care mental health for county mental health services.

Lack of Choice (in provider selection due to long travel distances)
- Create a menu of stigma reduction choices available in rural communities. Distribute these fliers/pamphlets at basic community services (grocery store, fire department, community pool, schools, etc…)

Other
- *Ensure enforcement of the Americans with Disabilities Act (ADA), the Fair Housing Act, [housing], and other state and federal non-discrimination policies and laws. Enforcement of the ADA would ensure that customers and clients with mental and physical disabilities are able to access all merchant and government services. Enforcement of the Fair Housing Act would ensure that housing applicants would be treated equally by housing providers, would be able to gain access to mainstream and*

specialized housing, and would not be steered to housing that segregates disabled tenants from non-disabled tenants or that segregates based on type of disability. Enforcement of the Fair Housing Act would also ensure that disabled tenants are not evicted if the owner's provision of reasonable accommodations and modifications eliminate the need and/or reason to evict.

- Educate the public that the lack of funding for mental health services compared to other health services IS discrimination.
- Identify stigma reduction programs that already exist and bring them into schools and other community services.

Outreach Methods
- Develop partnerships with agencies and organizations that have access to local rural communities/residences (schools, fire departments, police, etc). Provide support and stigma reduction information to these agencies so that they can be the primary provider of information and help spread the message
- Develop community based media campaigns (TV, radio, news, etc.) using local family/consumers as agents of change.
- Develop stigma and discrimination reduction activities in communities to eliminate class-based discrimination in mental health issues. Class based discrimination is often particularly prevalent in rural communities, where poverty tends to be more wide spread.
- Pair mental health presentations within community presentations about other topics.
- *Use local major TV stations that reach across 4-6 counties, putting a message that incorporates contact information for many local counties.*

Peer Support
- Support and empower consumers/family members to implement stigma and discrimination reduction ideas through peer support networks in rural areas.
- Create groups for activities unrelated to mental health so that peers become more than their illness.

Stigma Issues Specific to Small Communities
- Acknowledge that stigma associated with mental health issues may lead to physical isolation in rural communities.
- Acknowledge that families may actively isolate individuals with mental health issues to keep the community at large from knowing.
- Acknowledge that the small size of rural communities allows everyone in that community to know "everyone's business."

Technology
- Use communication technology (radio, internet, etc) to address stigma reduction issues in rural areas.
- Utilize telemedicine to provide increased choice and access to mental health services in rural communities.

Training and Education
- Teach non-stigmatizing language to mental health professionals.

- Provide advocacy training to consumers and family members.
- Provide stigma reduction training for basic community service providers such as postal workers, grocery store clerks, and first responders (i.e., "regular people" separate from the mental health system).
- Provide stigma reduction training for faith-based professionals and clergy members.
- Educate the community about *existing* ADA and other anti-discrimination laws AND the consequences of violating these laws.
- Educate rural court judges on mental health issues.
- *Introduce anti-stigma campaigns into elementary, middle, and high schools, and community colleges. The Southern Poverty Law Center has award-winning educational programming for anti-stigma campaigns. See, "Teaching Tolerance," http://www.splcenter.org/center/tt/teach.jsp*

Transportation
- *Develop transportation networks for trips to health services. Research local community and county compliance with ADA requirements for para-transit, sidewalks, and equivalent services.*
- Promote the co-location of medical and mental health services to reduce travel time in rural areas.

VII. Homelessness

Initial discussions with stakeholders show that the issue of stigma and discrimination towards mental health issues in homeless populations is at its core an issue of *dual* stigmas. Stakeholders unanimously agreed that homeless populations, with or without mental health challenges, are heavily discriminated against by society at large. While mental health issues are a significant concern in homeless populations, stakeholders generally agreed that housing is the most important issue to address.

Some examples of stigma and discrimination towards homeless populations identified by the workgroup included:
- The myth that homelessness is a homogenous issue. Not all homeless individuals became homeless in the same way, and different parts of the homeless population have different needs.
- The "invisible" treatment of many homeless people by society at large.
- The difficulty of locating affordable housing developments in existing neighborhoods.
- The difficulty of obtaining medical or other services without a physical address.
- Lack of any homeless voices at public meetings, even if the policies being decided directly affect homeless populations
- The need to educate the medical community about the special needs of homeless individuals.
- The fact that homeless individuals and families are more likely to become victims of violence than society at large.

The significant discrimination towards homeless populations manifests itself in a variety of ways, and leads to several specific problems for individuals who also suffer from mental health

problems. For example, stakeholders noted that individuals with mental health problems sometimes avoid first responders and case workers in fear of involuntary commitment.

The coincidence of a significant population of homeless individuals who also suffer from mental health issues is substantial and should not be overlooked, but mental health issues do not *per se* lead to homelessness and visa versa. For this reason, stakeholders suggested that <u>the first and best strategy for addressing the dual stigmas of mental health problems and homelessness is to provide housing first</u>. A number of programs, such as Housing First, exist to support this end. These programs should be voluntary, but only after a stable housing environment is established can individuals receive the treatment necessary to recover from any mental health problems.

In addition to the "housing first" principle, the National Coalition for the Homeless (NCH) developed five principles for ending homelessness:[1]
1. The McKinney Vento programs authorized by Congress in 1987 must be reauthorized and fully funded.
2. The supply of affordable housing available to the homeless must be dramatically increased.
3. Healthcare, education, and other services must be provided to all who need them.
4. Personal incomes must be sufficient to provide the basic necessities.
5. Discrimination against homeless people must be prevented.

The NCH reinforces many of the stakeholder's statements that housing needs are of paramount importance in addressing homelessness issues in general. However, discrimination against homeless populations and access to basic services is also critically important when discussing homelessness in general, and more specifically the unique challenges facing homeless individuals who also suffer from mental health problems. Additional strategies identified by stakeholders to address the dual stigmas of mental health problems and homelessness include:
- Create a centralized clearinghouse database related to why people become homeless.
- Create a task force to look at how laws are written that discriminate against homeless people and expand enforcement mechanisms for existing anti-discrimination laws.
- Build capacity for client owned and operated housing, but not limit it to supportive housing and crisis alternatives.
- Develop specialized programs for partnership subgroups of homeless populations (i.e. veterans, older adults).
- Establish public awareness guidelines for first responders, case managers, therapists and community outreach staff that use an integrated approach towards the person (does not only see homelessness) during an assessment. Develop questionnaire where an assessor is required to initial to sign off.
- Fund legal advocacy to make sure the "Not In My Back Yard" (NIMBY) ideology does not succeed. Use residents within the community to talk to their peers about best practices.
- Peer lead MHSA public outreach efforts.
- Adopt a 10 year plan to end homelessness.

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[1] National Coalition for the Homeless (2007). *Entering the Third Decade of the National Response to Homelessness in America: A Consensus Statement on Five Fundamentals.* Retrieved January 15, 2009, from http://www.nationalhomeless.org/publications/fivefundamentals/Five_Fundamentals_Statement.pdf.

VIII. Older Adults

1. **Education – develop an education *and training* plan to *address self-stigma*, *public stigma, and institutional stigma and discrimination that will* promote access to and use of mental health services**

- **Older Adults**
    - o Healthy aging is possible
    - o Common stressors and responses
    - o Solutions
- **General Public (includes families)**
    - o *The "Stamp Out Stigma" program is a model community education program in California to address self-stigma and public stigma, and to eliminate discrimination. It was developed and is implemented by consumers. Contact Carmen Lee for more information:* www.stampoutstigma.org; CarmenSOS@aol.com
    - o *Use a model which emphasizes that everyone's health, including mental health, is on a continuum from prevention through serious illness, and that conditions move back and forth, over time and circumstances.*
    - o *Develop Co-occurring groups specific to older adults.*
    - o *Note: Frequently older adults are excluded from alcohol/drug rehab. groups because they are on multiple meds, including anti-anxiety drugs, for other conditions. They also report feeling out of place since many attendees are Prop 36 related younger people who have to attend these programs. Alcohol and prescription drug abuse are predicted to be huge problems for older adults in the coming years.*
- **Service Providers**
    - o Health Care (mental health, physical health, substance abuse)
        - ▪ Mandatory continuing education on cultural competency approaches
        - ▪ Resources available/assessment
    - o Gatekeepers – "Keeping your distance is over-rated"
        - ▪ Pharmacists
        - ▪ Senior centers
        - ▪ Barber and beauty shops
        - ▪ Meals on Wheels
        - ▪ *Faith-based organizations/clergy*

2. **Marketing – Develop PSAs and media messages**
Develop a budget/timeline from Stigma & Discrimination MHSA funds for media campaign
- ▪ Hire a professional marketing firm to develop a media campaign
- ▪ Revisit the concept of the "tipping point" to identify locations, means, and methods for message delivery.
- ▪ Take advantage of the current bad economy to deliver no-fault media messages about what depression looks like
- ▪ If possible, use celebrities mixed with real people in media campaign

- Refer to the document "<u>Mentally Health Aging:</u> *<u>A Report on Overcoming Stigma for</u>* *<u>Older Americans</u>" published by SAMHSA. (Please include information from the "Mentally Health Aging" report in the Strategic Plan for Stigma and Discrimination Reduction, including the examples of educational and media campaigns along with the examples of media messages strategies, and target audiences to address <u>self-stigma</u>, <u>public stigma</u> and <u>institutional stigma</u>. This report also discusses the issue of ageism that can result in institutional discriminatory policies and bias in funding priorities. Examples of media messages include: "Treatment Works. Older adults with mental illness can improve and recover," "You deserve to feel well," "Strong mind, strong bodies," "Depression is not a normal part of aging" and more.*

2. **Label Services to be culturally competent/acceptable to Older Adults**
- Name OA mental health with alternate wording (e.g. "Elder Wellness")
- Use verbiage OAs can relate to (e.g. "Battle fatigue" vs. "PTSD" or "depression")
- Normalize and externalize through language
- Goal: decreased self-stigma of OA population

3. **Co-Locate** *Mental Health* **Services** *with services that are "acceptable" and "accessible" to older adults, to reduce stigma and improve access.*
- Combine primary care/mental health services in same location – be sensitive about labels
- *Provide mobile/in-home services for homebound seniors*
- *Utilize telephone, computer and other technologies to address stigma and promote access (i.e., telephone counseling.)*
- Locate certain services at senior centers, nursing homes, congregate living facilities (e.g. Del Webb)
  - Senior peer counseling
  - Support groups
  - Family/caregiver groups/workshops
  - Referral resources for other mental health services

4. **Education – develop an education** *and training* **plan to** *address self-stigma, public stigma, and institutional stigma and discrimination that will* **promote access to and use of mental health services**
- **Older Adults**
  - Healthy aging is possible
  - Common stressors and responses
  - Solutions
- **General Public (includes families)**
  - *The "Stamp Out Stigma" program is a model community education program in California to address self-stigma and public stigma, and to eliminate discrimination. It was developed and is implemented by consumers. Contact Carmen Lee for more information:* www.stampoutstigma.org; CarmenSOS@aol.com
- **Service Providers**
  - Health Care (mental health, physical health, substance abuse)

- Mandatory continuing education on cultural competency approaches
- Resources available/assessment
  - o Gatekeepers – "Keeping your distance is over-rated"
    - Pharmacists
    - Senior centers
    - Barber and beauty shops
    - Meals on Wheels
    - *Faith-based organizations/clergy*
    - *Others*

5. **Fairly distribute resources to Older** *Adults (This addresses the issue of institutional discrimination and ageism as it relates to access and utilization of mental health services.)*
- Older Adult SOC should be represented as a separate entity throughout MHSA (DMH, OAC, CMHDA) policy and program implementation
- Develop policy regarding Older Adult discrimination (e.g. some people avoid mental health clients out of fear of disruptive behavior)
- *Examine apparent disparities in access to public mental health services by older adults in general, as well as older adults from diverse populations. Understanding the reasons for these disparities is necessary as it might be a result of age bias/discrimination in mental health policy development, and budget allocation and expenditure decisions.*